

Doctor in trouble—a service committee hearing

Stefan Cembrowicz

The mistake was absurdly simple, caused great mischief, and was none of my doing. One Saturday night I was called to an inner city probation hostel to see an ex-athlete with a chronic tear to a thigh muscle. The patient complained of much pain and said that he was already taking paracetamol and "di-something" but was vague and unhelpful about the details.

Medication is locked away at the hostel as the misuse of drugs (such as diazepam, dihydrocodeine, and even diamorphine) is widespread. The warden produced the paracetamol and cephadrine from a cluttered safe, so I prescribed the anti-inflammatory drug diclofenac (Voltarol), having supplied a dose from my bag.

Three days later the surgery received a furious telephone call. The patient claimed that I had attempted to kill him by giving him a double dose of diclofenac (Voltarol) and promised legal action. He had previously been prescribed diclofenac in hospital and had a box of this at the back of the safe. He had not obtained the script for several days, and a staff member had spotted the duplication before any had been taken. I hastened round to check that he was all right, but he refused to see me or consider our in house complaints procedure, and announced that he would sue me.

A complaint to the family health services authority followed. Despite my having worked

closely with the hostel staff for 15 years, there was a major contradiction between my written explanation and that of senior staff, who denied all responsibility. This was strange as the warden concerned had telephoned to apologise. A formal hearing was therefore inevitable. During the next five months more enjoyable work including audit and research ceased. My thoughts strayed on to the case while seeing patients or trying to sleep, and my wife worried too.

The committee consisted of three general practitioners (one retired and one private) and three lay people. The hearing took place after lunch on a warm afternoon. The attention of the more elderly members of the panel seemed to wander at times and one seemed to fall asleep. My impression was that my clinical records were scanned rather perfunctorily, and any attempt to discuss points with the panel was met with silence.

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What I felt was animosity in the questions and body language of some of the panel members. I did not feel that I was being impartially judged by my peers.

I have attended the crown court as a witness in murder trials and I was surprised by the contrast between the focused questioning of barristers and the quasilegal efforts of the service committee. As the proceedings are inquisitorial rather than adversarial it was hard to judge which way each point went or to test the logic of decisions reached—those asking the questions

also deciding the verdict. Although there are 72 drugs in the *British National Formulary* starting with "di," should I not have realised that my patient was describing diclofenac, even if I wasn't shown it?

The five month wait had done nothing to calm my ex-patient, who shouted angrily during my testimony. After two and a half hours the chairman concluded the hearing, and courteously apologised to the patient for the stress and disruption caused by the delays. I waited in vain for some similar remarks to myself.

A month later I was perplexed to hear that I "had not put myself in a position to establish the complainant's drug regime," and I was instructed "to comply more closely with my terms of service." My partners decided not to continue to work with the hostel and resigned from the advisory committee.

I do not accept the committee's reasoning and feel that the only honest course of action is to appeal, which takes another year.

The service committee procedure started in 1947 as neither complaint nor disciplinary procedure, but was aimed at enforcing the terms of service. In today's culture patients are consumers, and complaints are encouraged by the patient's charter as a way of improving the system.

But doctors are consumers too, and we expect more democratic treatment rather than the proposals in the Wilson report on complaints procedure with more delays and less professional input. I resent the fact that I have been blamed for this mistake and that the service committee had no inkling of the problems of inner city general practice. If I cannot respect this tribunal then their verdict is irrelevant, and their efforts are counter-productive, and their admonishment will have been in vain.—STEFAN CEMBROWICZ is a general practitioner in Bristol

Philosopher assisted suicide and euthanasia

Carl Elliott

Legal euthanasia and assisted suicide are beginning to look inevitable, yet many doctors seem uncomfortable with the idea. The BMA has opposed legalising euthanasia and so have many states and national medical organisations in the United States. A recent bill making Australia's Northern Territories the world's first jurisdiction to legalise active euthanasia was bitterly opposed by the

Australian Medical Association. Even doctors who want to make euthanasia legal often say that they would not want to participate.

In this, as in other things, philosophers think differently. While there is certainly not unanimity among them—some moral philosophers express deep concerns about euthanasia—academic philosophers have been prominent among those arguing for ethical and legislative changes in current euthanasia policies. Philosophers have rightly pointed out that euthanasia brings about a quicker death for patients who are suffering, and on humanitarian grounds this is preferable to a more prolonged death. Philosophers have also argued, again persuasively, that it is difficult to make rational moral distinctions between withdrawal of life sustaining treatment, which doctors have come to believe is ethically acceptable, and active euthanasia, which many doctors apparently believe is not. Philosophers rather than doctors reflect the views of the public, which in many countries

seem sympathetic to the idea of physician assisted death.

When a majority of the public and philosophers support euthanasia and assisted suicide but doctors do not, there is a clear solution: let philosophers do the job. Legislation should authorise philosophers to perform euthanasia and assisted suicide. Lethal injection is a technically uncomplicated procedure that philosophers could easily learn to perform. It is already employed in several United States jurisdictions as a means of capital punishment without the aid of doctors. Assuming that the customary safeguards proposed to prevent abuse of a euthanasia policy could be implemented, this proposal would remedy the problems that make doctors worry about a policy of active euthanasia and assisted suicide.

The reasons many doctors give for opposing active euthanasia have become familiar: it would contravene professional oaths and codes of ethics, violating the moral

norms of a long professional history; it would damage the relationship between doctors and patients, casting doubts in the minds of patients about the goals of life and health to which their doctors are committed; and it would be a step down a slippery slope leading to morally objectionable forms of euthanasia, such as involuntary euthanasia for the disabled.

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But philosopher assisted suicide and euthanasia would avoid all these problems. Philosophers have no professional oaths and codes, and they are unencumbered by the traditions that seem to make many doctors reluctant to perform euthanasia. Nor is there usually a relationship between philosophers and patients that a policy of euthanasia might damage. More importantly, philosophers see distinctions between acceptable and unacceptable forms of euthanasia—distinctions that are apparently invisible to many doctors—that they believe would prevent a

slide down the slippery slope. And they have the additional advantage of failing to see the distinctions that doctors see between withdrawing life sustaining treatment and administering a lethal injection that prevents doctors from endorsing the latter.

Some philosophers may think that their background and education have not supplied them with the training necessary to carry out euthanasia. This may well be a legitimate worry. But many doctors feel the same way.

Euthanasia has not traditionally been a major focus of medical education. Indeed, apart from the technical knowledge that would ensure that death is swift and painless, it is not entirely clear what the relevant skills to perform euthanasia would be. Whatever they may be it seems reasonable to think that if doctors are capable of learning them philosophers are too.

Some philosophers, like many doctors, will naturally worry about the way philosophers will come to be seen if they are given the authority to participate in euthanasia. But this worry presumes that euthanasia is an ethically objectionable intervention. If euthanasia is genuinely praiseworthy from an ethical point of view carrying it out should reflect well on philosophy and will only enhance the philosopher's professional reputation. Of course, if philosophers have personal moral objections to active euthanasia they should be free not to practise it.

As many philosophers also realise, there is a difference between thinking it best that something should happen and thinking that you should do it—between thinking that it would be best if a person were to die and thinking that you ought to kill him or her. The latter involves questions of personal moral responsibility for ending a human life that philosophers may be reluctant to take on. If

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so, then perhaps we should reconsider the implications of asking a profession to take on a duty for which it feels ill equipped, about which at least some of its members have deep moral reservations, and which carries such potentially grave consequences for those to whom that duty might be directed.

I thank Fonds pour la Formation de Chercheurs et l'Aide à la Recherche (Quebec) for financial support and Charles Weijer for his comments.—CARL ELLIOTT is professor of medicine, ethics, and law at McGill University, Montreal

MEDICINE AND THE MEDIA

British and American media response to a paper in the *British Journal of Epidemiology and Community Medicine* (1996;50:481-96)

Transatlantic storm in a teacup

Earlier this month an American paper was published in the United Kingdom indicating a link between induced abortion and breast cancer. Conspiracy theorists emerged in force on both sides of the Atlantic, but the contrast between the way the British and American press reported the paper could hardly have been greater. While the British press, for the most part, reported the findings with a dispassionate calm, the American press indulged in a blitz of antiabortion conspiracy theories that would have bemused even Machiavelli.

It was this contrasting approach by the media in Britain and America that reportedly led the paper's author, Professor Joel Brind, to publish his research in a British journal which he assumed American medical reporters did not routinely read. So it was that the *Journal of Epidemiology and Community Health*, one of the specialist journals owned by the BMJ Publishing Group, enjoyed its 15 minutes of mid-Atlantic fame. The research, from Joel Brind, professor of endocrinology at the City

University, New York, and colleagues showed that a single abortion can significantly increase the chances of a woman developing breast cancer in later life.

Even before the press conference Professor Brind held to publicise his research, the critics were circling his camp. The *Wall Street Journal* on the day of the press conference carried the headline "Study on abortion and cancer spurs fight." It stated: "proponents of the study say that science, not politics, requires them to warn about the potential 'tragedy' of failing to alert women of the dangers they face when they have an abortion. But critics claim that politics, not science, is behind the study." The report quoted a succession of critics attacking Professor Brind's data and pointing out that the professor had previously published papers in "the organ of the National Right to Life Committee, the leading anti-abortion group in the US."

What would normally have been mundane production problems at the *Journal of Epidemiology and Community Health* had only fuelled the conspiracy theories. The journal's publication had been delayed by several weeks, so alas, Professor Brind's press conference preceded publication of his paper. The *Wall Street Journal* sniffed the scent of a fix. How come the article was being press released before it had been published, the newspaper inquired. On hearing the explanation of the journal's production difficulties, the newspaper's reporter asked what the *BMJ*'s response would be to the suggestion that the

BMJ was being manoeuvred politically because abortion was such a sensitive issue in America. This bizarre suggestion was strongly refuted, and it was made clear that the decision to publish the paper was based solely on the scientific merits of the article.

All in all, more column inches were devoted to the paper's critics than to the research itself. Professor Brind had argued that although the first published evidence of the link between induced abortion and breast cancer had come in 1957, there seemed to have been a deliberate attempt to play down the findings. His critics responded by questioning the professor's objectivity, accusing him of sensationalising his work and pointing out that he had previously published articles in magazines supported by antiabortion groups.

Back in Britain there was little interest in political conspiracies. The press focused its angst on what appeared to be a deliberate breach of the embargo chosen for reporting of the Brind paper but in fact turned out to be more cock up than devious conspiracy.

While the British Pregnancy Advice Service set up a telephone helpline for women worried by the media reports, the real burden fell once again on family doctors in both continents who faced a week of consultations with anxious women. Meanwhile the conspiracy theorists were left practising their aim in readiness for the next onslaught—NIGEL DUNCAN, *BMA head of public affairs*